Consumers for AFFORDABLE Health Care COALITION

Advocating the right to health care for every man, woman and child.

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June 23, 2006

VIA U.S Mail and Electronically

Alesssandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon
Docket No. INS 06-900
Maine Bureau of Insurance
34 State House Station
Gardiner, ME 04333-0034

IN RE: **REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECONDASSESSMENT YEAR (2007)**

Dear Superintendent Iuppa:

Please find enclosed for filing in the above captioned matter, two (2) copies of the following documents from Consumers for Affordable Health Care (C.A.H.C.):

SUMBITTED BY: Joseph P. Ditré
Legal Counsel to Consumers for Affordable Health Care

DATE: Friday, June 23, 2006

DOCUMENT TITLE: Intervenor Brief for Consumers for Affordable Health Care

DOCUMENT TYPE: Intervenor Brief

CONFIDENTIAL: No

Thank you for your attention in this matter.

Respectfully submitted,

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECOND ASSESSMENT YEAR	)	**Consumers for Affordable Health Care**
	)	**Intervenor Brief**
Docket No. INS-06-900	)	

Pursuant to Section I of the Superintendent's Order on Intervention and Procedures, Consumers for Affordable Health Care ("CAHC") hereby files its Intervenor Brief.

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Exhibits:

1 - Appendix F, "Compound Growth Rate in Excess of Inflation," Final Report: Dirigo Health Savings Offset Payment (SOP): Methodology and Calculations, September 19, 2005 (Mercer Government Human Services Consulting), *MAHP v. Superintendent*, Binder 2, at page 278

2 - "Draft Payor Caucus Report to the Dirigo Health Board of Directors Re: the Measurement of Savings under the Dirigo Health Initiatives (08-24-05 Draft)," Attachment 4, *MAHP v. Superintendent*, Binder 2, at p. 121

3 - Mercer Government Human Services Consulting **Review of Board's Decision**

4 – CAHC FOAA Request to Dirigo Health Agency (June 20, 2006)

Introduction

The Dirigo Health Act, P.L. 2003, Ch. 469, as amended by P.L. 2005, Ch. 400 (the Act"), established the Board to sponsor affordable health care for low-income Maine citizens with subsidies coming from annual assessments on insurers and third party administrators based on savings determined by the Board from initiatives to reduce costs in the health care system. The Act provides for the subsidies to be established through three distinct administrative stages: *first*, the Board each year determines the "aggregate measurable cost savings" in the health care system attributable to Dirigo Initiatives; *second*, that determination is subject to review by the Superintendent as to whether the savings found by the Board are reasonably supported by the evidence in the record; and *third*, the Board establishes a "savings offset payment" ("SOP") to be assessed against insurers and third party administrators that may not exceed 4% of paid claims or the aggregate measurable cost savings as approved by the Superintendent. The SOP is then used to subsidize Dirigo insurance for income eligible insureds. We are at the second stage of the process.

Standard of Review

The Act requires the Superintendent to "issue an order approving, in whole or in part, or disapproving the filing made [by the board]." 24-A M.R.S.A. §6913(1)(C) Further, the Act requires the Superintendent to "approve the filing upon a determination that the aggregate measurable cost savings filed by the board are reasonably supported by evidence in the record." *Id.* In his Decision and Order in the first assessment year proceeding the Superintendent stated:

> "The Superintendent has interpreted 'reasonably supported by the evidence' to refer to the totality of the evidence and not to any part of the evidence taken out of context. Second Procedural Order. "Reasonably supported" is not a preponderance-of-the-evidence standard. *Id.* If more than one alternative for determining aggregate measurable cost savings could be reasonably supported by the evidence, Dirigo does not have to prove that its chosen alternative is more reasonable or better supported than another alternative. *Id.*"

R. 4712, Decision and Order, IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE FIRST ASSESSMENT YEAR, Docket No. INS-05-700, October 29, 2005, § I. A. at p. 2

Unlike the "substantial evidence on the whole record" standard found in 5 M.R.S.A. §11007(4)(C)(5), the standard here is more analogous to the "arbitrary and capricious" standard found at 5 M.R.S.A. §11007(4)(C)(6). It is not the amount of the evidence on the whole record but rather the "reasonableness" of the evidence supporting the board's determinations. Last year, in applying that standard, the Superintendent concluded that several of the board's determinations were not reasonable. For example, he determined that "[t]he market basket chosen was the 1992-based HMBI, which CMS now considers outdated, which is not reasonable. *See* Hearing Officer Exhibit 1. Replacing the 1992-based index with the 1997-based index, and retaining the same methods of calculating the average growth rate for the analysis, increases the three year average inflation rate from 11.2% to 12.5%, which in turn would reduce the estimated savings by approximately $7.6 million." R. 4720, Decision and Order, IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE FIRST ASSESSMENT YEAR, Docket No. INS-05-700, October 29, 2005, § V.B.1.a. at p. 10 The Superintendent also determined that Dirigo's use of 1.25% as the likely enrollment increase in MaineCare in the absence of Dirigo Health was unreasonable. He said, "However, Dirigo was unable to provide any factual support for this conclusion, and it is not reasonable to conclude, without such support, that the increase was twice what it would have been when the record shows that the 2.5% increase was actually lower than the 3.5% average annual increase over the previous three years." *Id.* at 4722 (Decision, at p. 12)

I. The Board's Use of a Median Rate of Growth In Its CMAD Calculation, Rather Than An Average Annual Rate of Growth As Adopted By the Savings Offset Payment Working Group, Used by the Board and Approved By the Superintendent for Year One Determination and Decision, Was Unreasonable.

In its First Assessment Year Preliminary and Final Reports, the Board used a compound annual rate of growth/geometric mean to calculate CMAD. The Board made clear that its use of a compound annual growth rate/geometric mean was based on the recommendations of the Savings Offset Payment Working Group. Appendix F, "Compound Growth Rate in Excess of Inflation," Final Report: Dirigo Health Savings Offset Payment (SOP): Methodology and Calculations, September 19, 2005 (Mercer Government Human Services Consulting), *MAHP v. Superintendent*, Binder 2, at page 278. Exhibit 1 attached In Appendix F, the Board, through its consultant, stated: "A second adjustment to the growth rate calculation suggested by the SOP Workgroup was to use compound rather than average growth rates over the a baseline period 2001 – 2003. Thus, after inflation was taken out of cost growth over the baseline period, the baseline growth rate was the compound growth rate (CGR). The CGR is slightly lower than the average growth rate over 3 years." Id. at p. 278. The Payor members of the Savings Offset Payment Working Group insisted, and the full membership of the Working Group agreed, that a compound annual growth rate ("the geometric mean") was the most accurate method to measure the CMAD. Id., Attachment 4, at p. 121 Exhibit 2 attached The Draft Payor Caucus Report states at page 6, item number 3: "The historical growth rate should be computed as a compounded (or 'geometric') average rate of growth rather than just the arithmetic mean of the annual growth rates." Id. at 121 The Board included the "Draft Payor Caucus Report to the Dirigo Health Board of Directors Re: the Measurement of Savings under the Dirigo Health Initiatives (08-24-05 Draft)" to support its use of the compound annual growth rate in calculating the CMAD. The Board underscored the importance of using the compound annual growth rate/geometric mean by including a matrix labeled "SOP Methodology Matrix: Final Workgroup Proposal With Compromises." Id. at 106 – 115. The Superintendent approved the use of three-year average annual growth rates as provided in the CMAD section of his decision and in the Uninsured Initiative section of his decision as shown in the examples in Section

1 above. In all relevant calculations performed by the Superintendent in his First Assessment Year decision, he used average (mean) annual rates of growth over a three-year period. In no calculation did the Superintendent use a median rate of growth.

This year, in its presentation to the Board, the Agency made clear that it was following the methodology that the Board had adopted last year, as modified by the Superintendent's decision, to calculate CMAD using a compound rate of growth. It was not reasonable for the Board to adopt a new, untested and unpredictable methodology based without factual support. R. 5259 - 5266 (Binder 11). Just as the Superintendent determined in his First Assessment Year Decision that it was not reasonable for the Board to use a 1.25 percent growth rate without factual support when the three-year annual average rate of growth for MaineCare enrollment was 3.5%, it is not reasonable for the Board to adopt a median rate of growth without factual support. The Supreme Judicial Court of Maine has stated: "We do not find that an administrative agency has acted arbitrarily or capriciously unless its action is 'wilful and unreasoning' and 'without consideration of facts or circumstances.'" *Kroeger v. Dept. of Environmental Protection*, et al., 2005 ME 50, 870 A. 2d 566 (Me. 2005) *citing Cent. Me. Power Co. v. Waterville Urban Renewal Auth*, 281 A.2d 233, 242 (Me. 1971)

In its review of the Board's decision, Mercer Government Human Services Consulting ("Mercer") provides an analysis with calculations that makes clear why it was not reasonable for the Board to adopt a median growth rate. Exhibit 3 attached CAHC obtained the Mercer review through a Freedom of Access Act request to the Dirigo Health Agency dated June 20, 2006. Exhibit 4 attached The major point that the Mercer review and analysis makes is one that Director Beal of the Dirigo Health Agency Board articulated on May 12, 2006 at the board deliberations. It is the failure of the median to predict the rate of growth of hospital costs per case mix adjusted discharges

going forward based on what cost growth has actually occurred in Maine's hospital pricing system.

Director Beal said:

> Secondly, I think one of the, one of the biggest issues I see is the growth rate assumptions. I've looked at the Chamber documents including particularly Exhibit 21 with Shields' determination with respect to projected percentage growth and based on prior projected growth. And Mr. Shields in particular was concerned about utilizing the 10.1 percent 2002 growth figure in projecting forward. He suggested, as I recall, one possibility was using a median figure. *The problem with a median figure in my mind is that if you use a median figure such as 4.7, it ignores the fact that the 10.1 percent increase occurred and that its effects are still in the system. By choosing a median from 2001, you don't necessarily include the fact that costs are up based upon that 2002 increase.* (Italics added) R. 5257 – 5258 (Binder 11)

Mercer's analysis of the Board's May 12, 2006 decision supports Director Beal's conclusions.

Mercer states:

> Table 2 addresses how the various measures are calculated and their predictive properties. In general, the mean and median each have advantages and disadvantages when used to describe data sets. Overall, however, the mean depends on all of the actual values in a data set, but the median is dependent on only one of the actual values and its relative position among the values, not the actual values themselves, and this is extremely important when using either of these measures for their predictive properties. Ex. 3 at p. 2

Table 2, replicated below, shows why the geometric mean is predictive of annual growth rates over time and the median is not.

[Complete Table 2 on next page]

Table 2. Mean vs. Median: Projecting CMAD Forward

	Arithmetic Mean	Geometric Mean	Median
Calculation	Add the 3 annual percentage increases and divide by 3. (4.72+10.12+3.32)/3	Take the cube root of the 3 annual growth factors. Subtract 1 to convert to a percentage increase. $(1.0472 \times 1.1012 \times 1.0332)^{1/3}$ -100%	Determine which of the 3 percentage increases is where half the values are above and half are below. 10.12 High 4.72 Midpoint 3.32 Low
Result	6.05%	6.01%	4.72%
Role	Tells what the average rate of increase was from 2000 to 2003	Tells the actual compound annual rate of increase from 2000 to 2003	Tells the relative distribution of each of the three years' percentage increase
CMAD Predictive Value for 2003	$\$4,868 \times (1.0605)^3 = \$5,806$	$\$4,868 \times (1.0601)^3 = \$5,800$	$\$4,868 \times (1.0472)^3 = \$5,590$
CMAD Actual 2003	$5,800	$5,800	$5,800
Difference	($6)	$0	$210
Conclusion	The arithmetic mean, based on the actual values, is an excellent predictor of the CMAD actual value for 2003, with an error of only $6	The geometric mean, based on the actual values, exactly predicts the CMAD actual value for 2003, with no error ($0).	The median, which looks only at the relative distribution of the values, is an extremely poor predictor of the CMAD actual value for 2003, with an error of $210.
Bottom Line	The error using the median is on the order of magnitude of the annual variations in CMAD and so clearly illustrates the inappropriateness of the using the median.		

Mercer analyzes the difference between the CMAD Predictive Value for 2003 and the CMAD Actual 2003 Value. The Geometric mean shows a zero dollar ($0) difference between the predicted value ($5800) and the actual value ($5800) of the 2003 CMAD while the difference between the Median predictive value ($5590) and the actual value ($5800) of the 2003 CMAD shows a $210 difference. Mercer concludes: "The geometric mean, based on the actual values, exactly predicts the CMAD actual value for 2003, with no error. The median, which looks only at the relative distribution of the values, is an extremely poor predictor of the CMAD actual value for

2003, with an error of $210." Ex. 3 at p. 3 Further, Mercer in the row labeled "Bottomline" in Table 2 states: "The error using the median is on the order of magnitude of the annual variations in CMAD and so clearly illustrates the inappropriateness of the using the median."

Mercer also provides a sample analysis in Table 4 to illustrate how the actual dollar value of the CMAD can remain the same yet the median fluctuates dramatically. Table 4, "Example Mean vs. Median: Projecting CMAD Forward," in the row labeled "Bottomline" states: "The ending CMAD is identically to the actual 2003 CMAD in this example ($5800), yet the median has increased dramatically from 4.72% in the actual to 6.00% in this case. On the other hand, both of the mean calculations have remained essentially unchanged. This example clearly shows the advantage of using the mean – while the median may be a good predictor of the actual values (depending upon the relative distribution of the values), the mean, and especially the geometric mean, by definition will exactly predict the actual value." (Italic in original) Ex. 3 at p. 4

Conclusion

It was not reasonable for the Board to adopt a new, untested and unpredictable methodology based without factual support. The Superintendent made numerous changes to those of the Board's methodologies that he determined not reasonable in the First Assessment Year. We believe that the use of the median rate of growth is not reasonable for all of the reasons stated herein.

In all other respects, the Board adopted the methodologies offered by the consultant to the Dirigo Health Agency with their modifications to reflect the Superintendent's Decision and Order from last year.

Dated: June 23, 2006

Respectfully submitted,

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Certificate of Service

I, Joseph P. Ditré, Esq., certify that the foregoing **Consumers for Affordable Health Care Intervenor Brief** was served this day upon the following parties via U.S. Mail and electronically.

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Exhibit 1 to CAHC Intervenor Brief

Appendix F: Calculation of SOP Related to Limits on the Growth in Cost Per CMAD

Nancy M. Kane,
Consultant to the Dirigo Health Agency
September 15, 2005

According to the Dirigo health care reform act, "each hospital…is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004." (Section F-1, 1B). The Dirigo Health Board is to establish a savings offset payment amount to be paid by health insurance carriers and other claims payers at a rate that "may not exceed savings resulting from decreasing rates of growth in the State's health care spending and in bad debt and charity care costs." (Section 6913, 2)

Methodology for Measuring Hospital Expenses, Case Mix, and Adjusted Discharges

Hospital Expense, Discharge and Case Mix

This analysis reports on the savings resulting from decreasing rates of growth in hospital costs per case-mix adjusted discharge (CMAD) during the Dirigo Fiscal Year July 1, 2003 to June 30, 2004, based on a cost and discharge methodology proposed by the Maine Hospital Association (MHA). In June, 2005, the MHA provided the consultant with a spreadsheet showing hospital CMAD for hospital fiscal year 2003, with costs taken from the Medicare Cost Report, Worksheet C, and case mix indices (using CMS case weights applied to all discharges) and discharges derived from discharge data provided by the Maine Health Data Organization (MHDO). Discharges were adjusted for outpatient activity according to the methodology proposed by the MHA:

Inpatient discharges (including newborns) multiplied by the Case Mix Index derived using CMS case weights applied to all payer discharges

Plus

Outpatient-adjusted discharges, calculated as Outpatient Gross Patient Service Revenue divided by Inpatient Gross Patient Service Revenue Per Inpatient Discharge.

The consultant used the MHA spreadsheet as a template off which she calculated the Baseline Years CMAD (2001-2003) and 2004 CMAD data, using the same data sources to determine 2000-2004 hospital expenses, discharges, and case mix indices. Minor modifications were made to the MHA template as described in Appendix A to enable year-to-year comparisons using consistent measurements and entities over the period of analysis.

Fiscal Year Adjustment

The cost data is provided in terms of hospital fiscal years, so it requires an adaptation to the Dirigo fiscal year in order to be compliant with the time period prescribed in the legislation (July 1, 2003 – June 30, 2004). Hospital fiscal years do not correspond to the Dirigo fiscal year (July 1 – June 30) for 26 of the 36 hospitals analyzed. To get to the Dirigo fiscal year, the analysis weighted the hospital fiscal year CMAD by the number of months of overlap with the Dirigo fiscal year, to come up with a Dirigo fiscal-year-adjusted CMAD. For the rest of this report, the term CMAD means CMAD adjusted to the Dirigo fiscal year.

Table 1 describes the hospital fiscal years and how they overlap to the 2003-2004 Dirigo fiscal year.

2004 Hospital FY Begins:	4/1/2003	5/1/2003	6/1/2003	7/1/2003	10/1/2003	1/1/2004
# Hospitals	2	2	1	10	13	8
# Months overlap with Dirigo FY 2004	9	10	11	12	9	6
Weighting scheme applied to hospital FY CMAD to match Dirigo FY*	.75*2004 +.25*2005	.83*2004+ .17*2005	.92*2004 +.08*2005	=2004	.25*2003 +.75*2004	.5*2003 +.5*2004

*2005 not yet available, so the SOP was calculated using only a partial year, but assuming the 2004 growth rate based on the 2004 data available.

It is appropriate from a practical and theoretical standpont to use is the Dirigo fiscal year as the basis for measuring cost containment effort, because hospitals knew about the cost limit possibility in the spring of 2003, during the development of the Dirigo Act. Thus hospitals were prepared to and subsequently did initiate cost constraints in accordance with the Dirigo fiscal year . The alternative possibility, that hospitals waited for up to 11 months after the Dirigo fiscal year began to initiate such constraints only at the beginning of their 2004 fiscal years is a less realistic assumption, and is not consistent with what representatives of the hospitals were saying at the Hospital Study Commission meetings this past year. During the fall and winter of the second Dirigo fiscal year (July 2004 – June 2005), the Hospital Study Commission was meeting regularly to discuss, among other things, the *third* fiscal year CMAD limit and how it should be set. The MHA, as a

member of those discussions, indicated that for Dirigo Year 2, hospitals had decided to raise their voluntary limit to 4.5%, and were already operating under that assumption.

Methodologies Involved in Calculating Baseline and 2004 Growth Rates

Hospital Market Basket Adjustment

In August, 2005, the Savings Offset Payment (SOP) Workgroup suggested that the SOP calculation should take into account Hospital Market Basket Inflation (HMBI). The HMBI reflects the rate of inflation for hospital input costs nationally – eg salaries and wages, benefits, labor, utilities, supplies, pharmaceuticals, liability insurance. It is determined by consultants to the CMS for purposes of determining updates to the Medicare Prospective Payment System. Since the annual HMBI is stated as though hospital fiscal years correspond to the federal fiscal year (October 1 through September 30), the annual HMBI had to be adjusted (using the quarterly data published by CMS that make up the HMBI) to match the Dirigo Fiscal Year of July 1- June 30. This resulted in annual HMBI of 4.2% in 2001, 3.1% in 2002, 3.5% in 2003, and 3.8% in 2004.

Compound Growth Rate in Excess of Inflation

A second adjustment to the growth rate calculation suggested by the SOP Workgroup was to use compound rather than average growth rates over the baseline period 2001-2003. Thus, after inflation was taken out of cost growth over the baseline period, the baseline growth rate was the compound growth rate (CGR). The CGR is slightly lower than the average growth rate over 3 years. For example,

CMAD 2000 =$4000
CMAD 2003 = $4700 after taking out inflation-related growth

Average Growth Rate = ((4700-4000)/4000)/3
= 5.83%
Compound growth rate = 5.52%[2]

Final SOP Methodology:

The methodology used to incorporate the HMBI and the CGR was to inflate each hospital's 2000 CMAD by the HMBI for the three years 2001-2003 to get an inflation-indexed CMAD for 2003. This inflation-indexed CMAD for 2003 was subtracted from 2003 actual CMAD; that difference represented the three-year (baseline) change in cost after adjusting for inflation. This numeric difference was used to calculate the compound rate of growth between 2000 and 2003 in excess of inflation. That compound growth rate became the "baseline growth rate".

[2] 4000*1.0552*1.0552*1.0552=$4700

To calculate the inflation-adjusted rate of growth for 2004, the 2004 HMBI inflation rate of 3.8% was subtracted from the actual growth rate of CMAD in 2004 over CMAD in 2003.

The SOP was the product of the difference between baseline growth rate and the 2004 inflation-adjusted growth rate, times the 2003 CMAD; that product was then multiplied by the number of 2004 case-mix and outpatient-adjusted discharges.

Hospital example:

1. Hospital 2000 CMAD of $4000
2. Inflated forward to 2003: $4000*1.042*1.031*1.035 = $4,448 (inflation-indexed 2003 CMAD)
3. Hospital 2003 actual CMAD = $5,125
4. Difference between 2003 actual CMAD and the 2003 inflation indexed CMAD is $677.
5. $677 increase over 3 years = 5.35% compound baseline growth rate (the rate of growth in excess of inflation for the three years 2001-2003).
6. Hospital 2004 actual CMAD = $5,304; this represents a 3.5% increase over 2003 actual CMAD (assumes hospital budgeted to hit the Dirigo CMAD target).
7. 2004 HMBI-adjusted growth rate is -.3% (actual 3.5% minus HMBI in 2004 of 3.8%)
8. Baseline inflation-adjusted growth rate of (1+5.35%) * 2003 actual CMAD = $5399, which is what 2004 CMAD would have been after inflation if it had grown at the baseline rate.
9. Inflation-adjusted growth rate is (1 -.003)*2003 actual CMAD or $5110 after adjusting for inflation.
10. Difference between $5399 and $5110 = $289 which is the savings per discharge in 2004.
11. Multiply the savings per discharge times the number of casemix-and outpatient-adjusted discharges, say 7,000 discharges = SOP of $2,023,000.

Table 2 shows the SOP by hospital, using the above methodology. The total SOP attributable to the CMAD voluntary limit for Dirigo Year 1 is roughly $75 million, generated by 22 hospitals out of the 36 acute facilities in Maine.

Table 2
SOP related to CMAD Growth Limit

Hospital	Baseline CGR > HMBI	2004 Growth Rate > HMBI	SOP
AROO	-0.004	0.030467	$0
BLHL	0.0178	-0.0388	$522,327
BRDG	0.0091	-0.09058	$1,487,122
CALA	0.0067	0.006852	$0
CARY	-0.0136	0.032596	$0
CMMC	0.0093	0.022227	$0
DEAN	0.0107	0.100586	$0
DNET	-0.0131	-0.03994	$448,070
EMMC	0.0383	-0.02139	$15,851,479
FRKL	0.0386	-0.05518	$3,489,372
HGGD	0.0025	-0.05922	$1,487,598
HLTN	-0.0223	-0.01974	$0
INLD	0.0099	-0.08337	$2,286,989
MECS	0.0349	0.07429	$0
MGNL	0.0257	-0.0266	$8,921,522
MMC	0.0216	0.008545	$4,570,562
MAYO	0.0076	-0.07333	$1,309,278
MRCY	0.0182	0.048158	$0
MDCS	0.0275	-0.03799	$3,468,018
MILES	0.0143	0.031798	$0
MLNK	-0.0217	-0.00049	$0
MDES	0.4172	0.035133	$5,749,712
NMMC	0.0748	0.011678	$1,343,575
PKVW	0.0184	0.032467	$0
PBMC	0.0417	-0.00917	$1,831,506
PVMC	0.1911	0.048233	$1,560,611
RDFW	0.0685	-0.04855	$3,616,655
RUMF	0.0646	-0.08716	$2,180,813
SBCK	0.0265	0.171647	$0
SMMC	0.0232	0.051809	$0
STEV	0.1588	-0.08537	$6,388,356
STAN	0.0821	0.033871	$294,907
STJO	0.0095	-0.0589	$4,249,608
STMY	0.0259	0.0217	$336,984
WLDO	0.0356	0.105979	$0
YORK	0.0355	-0.02814	$3,587,724
SUM:			$74,982,787

Appendix A: Adjustments to the cost and case mix data provided by MHA

MHA only provided hospital cost data for fiscal year 2003, using the Medicare Cost report Worksheet C, which excludes hospital bad debt and non-hospital expenses (home health agencies, longterm care facilities, hospital-owned physician practices). MHA also excluded the state provider tax in 2003, based on its records of hospital 2003 provider tax information. MHA used Worksheet C (part 1, column 1, line 103) for total hospital expenses, and then removed costs and revenues associated with Skilled Nursing Facilities, Nursing Facilities, and Other Longterm Care, as well as Rural Health Centers, using those specific line times in Worksheet C.

This same template was used by the consultant to construct hospital cost data for the years 2000, 2001, 2002, and 2004. 2004 was further adjusted to remove hospital-based physicians that had been external entities in 2003 (not included in the 2003 Medicare cost report) but had been consolidated into the hospital entity in 2004. These costs and revenues were identified primarily because of new cost centers with names like "Primary Care Physicians" in the MCR and/or huge jumps in existing "primary care" or "outpatient clinic" cost centers, where physician practice consolidation in 2004 could be identified through footnotes and supplemental cost and revenue information provided by hospital audited financial statements.

The 2004 hospital provider tax was also entered by the consultant, using information provided by the state regarding the amounts due and the timing of the tax levy. Combining the state information with that provided in hospital 2003 and 2004 audited financial statements, as well as the MHA information for 2003, the consultant was able to match tax levies to hospital fiscal year. For instance, for hospitals with fiscal years ending September 30, the 2003 levy (announced in November of 2003) was not recognized until hospital fiscal year 2004; for those hospitals, they recognized the 2003 full levy plus a proportionate share of the 2004 levy in 2004. Proportionate share was based on the overlap in hospital and state fiscal years, so for the September 30 hospitals, that overlap was 75% or 9 months.

The MHA used Worksheet C for all hospitals except Maine Medical Center (MMC) and Eastern Maine Medical Center (EMMC); for those two, it started with expenses from Worksheet A, which included more expenses than did Worksheet C (including educational and research expenses). While MHA then removed the educational and research expenses to arrive at a 2003 CMAD for these two hospitals, their CMADs were still higher than what would have been derived from Worksheet C's hospital expenses. It was not clear what rationale was behind using Worksheet A for these two hospitals, so the consultant used the Worksheet C data instead for EMMC and MMC, in order to maintain consistency.

Finally, the consultant had to estimate the all-discharge Case Mix Index (CMI) including newborns for 2000, because it was not possible to get that number in time for this analysis. We did have the 2000 CMI excluding newborns, so the CMI including

newborns was estimated using the average relationship of the CMI including Newborns to the CMI excluding newborns for the years 2001, 2003, and 2004, years for which both CMIs were available. (This same method was used to fill in the CMI for 2002).

Exhibit 2 to CAHC Intervenor Brief

Draft Payor Caucus Report to Dirigo Health Board of Directors Re: the Measurement of Savings under the Dirigo Health Initiatives (08-24-05 Draft)

Introduction

The payor representatives of the Dirigo Health Working Group believe that the measurement of savings under Dirigo must be guided by three primary criteria:

- The savings must be ***directly attributable to the operations of Dirigo Health***;
- The savings must be ***measurable***; and
- The savings must ***accrue directly to payors (employers and consumers)***.

These criteria are directly supported by the Dirigo law itself, which requires the Dirigo Health Board of Directors to determine "***the aggregate measurable cost savings***, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State ***as a result of the operation of Dirigo Health*** and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A MRSA § 6913(1)(A) (*emphasis added*). Furthermore, the criteria that the savings must accrue directly to payors is found in 24-A MRSA § 6913(7), which requires health insurance carriers and health care providers to demonstrate that best efforts have been made to ensure that carriers have recovered savings offset payments "through negotiated reimbursement rates that reflect health care providers' reductions or stabilization in the cost of bad debt and charity care as a result of the operation of Dirigo Health and any increased enrollment due to an expansion of MaineCare eligibility occurring after June 30, 2004."

The payor representatives firmly believe that in order to look at the aggregate savings, it is necessary to look at the entire system, not just those elements that result in savings while ignoring those that result in increased costs. While recognizing that the measures proposed cannot always be directly attributable to Dirigo Health initiatives, the payor representatives have attempted to propose reasonable and credible proxy measures or modifications to the proposals made. The payor representatives believe that it is critical that all measures result in understandable, reasonable and credible results to ensure broad-based understanding and support for the measurement process.

At the meeting on August 2, Mercer Government Human Resource Consulting, the actuarial firm hired by the Dirigo Health agency to assist in the development of the proposed methodology, indicated that it was difficult or impossible to develop a methodology that could attribute savings to the Dirigo Health reform initiatives, particularly with in the time frame allowed. The payor representatives agree with Mercer that it is difficult to attribute savings to Dirigo initiatives. In the spirit of compromise, however, the payor representatives were willing to consider an approach that would apportion some of the measured savings to the Dirigo Health initiatives, recognizing that it would be necessary to reach agreement on how much could fairly be attributed to the Dirigo Health program. Some portion of those savings attributable to Dirigo Health would then be recovered through the savings offset payment. This is particularly true if the savings cannot be directly attributed to the Dirigo Health initiatives, as is required by the law.

Neither of the methodologies for measuring aggregate savings put forward at this time meet the requirements or intent of the law, which contemplates a measurement of savings that is rigorous enough to ascertain the savings attributable to Dirigo and to allow those who must pay the Savings Offset Payment to be assured that their disbursements represent only a portion of the savings accrued as a result of Dirigo Health operations, not all of those savings and not another tax that will affect their ability to invest and compete in whatever market they operate in.

Notwithstanding that there is no rigorous actuarial or financial methodology that can be identified at this time that can identify the aggregate measurable cost savings resulting from Dirigo Health reform initiatives, some methodologies will be less flawed and arbitrary than others.

Methodologies that are fatally flawed and very arbitrary are those that (1) ignore the prices that private payors pay in the marketplace; (2) fail to recognize that health care providers and health insurance carriers operate in an environment where other external factors play a much larger role in determining cost and price increases, operating margins, and underwriting gains; and (3) attribute 100% of reduced cost or price increases or reduced margins/underwriting gain increases to Dirigo.

Methodologies that are less flawed and less arbitrary are those that (1) use the price data that private payors pay in the marketplace, and (2) recognize that there are external factors, outside the scope of Dirigo Health, that play a significant role in determining changes in price and margin/underwriting gain. Any attempt to measure the annual change to these indicators must also recognize that Dirigo Health reform initiatives are only partly responsible for the outcomes, and apportion those changes to the Dirigo Health initiatives on a reasonable statistical basis or by using another methodology that accounts for these additional factors.

The payor representatives recognize and appreciate the fact that the Dirigo representatives have made some changes to the proposed methodology, in an effort to address some of the concerns expressed. Nonetheless, the payor representatives believe that their proposed methodology is less flawed and less arbitrary than the methodologies developed by the Dirigo Health Agency and, therefore, represents a more viable and equitable proposal.

Payor Caucus Alternative Proposal

As an alternative to the voluntary hospital targets (COM and CMAD) and the uninsured/underinsured (bad debt and charity care) measures, the payor representatives suggested an approach that would measure changes in a hospital's approved charges over time.

Exhibit A outlines the manner in which a typical hospital would calculate its Gross Patient Service Revenue (GPSR), which in turn will determine any changes in its charges that are required (either increases or decreases) to meet its annual budget. The calculation of GPSR includes a variety of factors, including changes in the hospital's expenses, the hospital's operating margin, the payments received by both public and private payors, and uncompensated care.

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Exhibit A (Calculation of Gross Patient Service Revenue):

$$GPSR = \frac{E - OOR - MP - MCP + OM}{1 - M\% - MC\% - PP\%(PPD) - CC\%}$$

Where:

GPSR = Total Charges
OOR = Other Operating Revenue
MP = Medicare Payment
MCP = MaineCare Payment
OM = Operating Margin
M% = Medicare % of charges
MC% = MaineCare (Medicaid) % of charges
PP% = Private Payors % of charges
PPD = Private Payors Discount
CC% = Charity Care % of charges

***Example** (in millions):*

$$GPSR = \frac{\$50 - \$1 - \$15 - \$10 + \$1}{1 - .40 - .25 - .30(0.05) - 0.5} \qquad \frac{25}{.285} \qquad GPSR = \$87.7$$

	Charges	Payments	% of Payments
Medicare	35.0	15.0	30%
MaineCare (Medicaid)	22.0	10.0	20%
Private Payors	26.3	25.0	50%
Charity Care	4.4	—	0%
TOTAL	$87.7	$50.0	100%

The proposed method for measuring savings using charges, which was outlined by the payor representatives at the August 9 meeting of the working group, would be calculated as follows:

Exhibit B: Example of Methodology for Measuring Hospital Savings (in millions)

	(1)	(2)	(3)	(4)	(5)	(6)
Hospital	**Average Annual Price Increase (2001-2003)**	**Dirigo Yr 1 Price Increase (2004)**	**Total Charges Private Purchasers (2003)**	**1x3**	**2x3**	**4-5**
1	8%	6%	$200	$216	$212	$4
2	6%	6%	$40	$42.4	$42.4	$0
3	6%	8%	$20	$21.2	$21.6	($0.4)
4	7%	5%	$50	$53.5	$52.5	$1.0
Repeat for hospitals 5-39						
Total	7%*	6%*	$1,000	$1,070	$1,060	$10

**Weighted averages*

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The payor representatives believe that this approach has a number of advantages over the hospital measures and the uninsured/underinsured measures proposed by the Dirigo Health Agency:

1. It is a simple and efficient measure that includes many of the components that the Dirigo Health Agency proposal tries to measure separately.
2. This measure, which establishes a clear "line of sight" between the Dirigo Health initiatives and their impacts on the prices paid by health care consumers and payors, essentially replaces the COM, CPAD, and the uninsured/underinsured (Bad Debt and Charity Care) measures, since all of these components are incorporated into, and affect the outcome of, this one measurement.
3. Although most consumers of health care do not pay charges, it is charges that determine what the consumer does pay, since the vast majority of Maine hospital reimbursement is a percentage reduction from charges.

Representatives of the Dirigo Health program expressed concern that the increases in charges would be difficult to confirm or verify, as they are not reported separately on hospital financial statements. In an attempt to address that concern, the payor representatives believe that it may be possible to develop a proxy using a "charges per adjusted discharge" methodology, which would utilize publicly available data, on an interim basis until the data necessary to perform the charge calculations can be captured for a period sufficient to enable the historical and ongoing calculations.

Additionally, the payor representatives expect that at least 50% of the aggregated total savings (summed from all the measures) be shared with the payors with 50% attributable to Dirigo Health for the determination of the savings offset payment assessment.

Voluntary Hospital Targets

- ***Consolidated Operating Margin (COM)***

The payor representatives understand that the methodology proposed by the Dirigo Health Agency ("DHA") seeks to:

- Calculate the historical three year average hospital consolidated operating margin ("COM") as the baseline margin for each hospital;
- Calculate the consolidated operating margin for 2004 as the baseline margin; compare to actual 2004 consolidated margin (on a per hospital basis);
- Calculate all decreases in consolidated hospital operating margins (by identifying only those hospitals that experienced a reduction in actual COM); and
- Sum the total of individual hospital savings to get total savings for 2004.

The concerns with this methodology include:

- That it does not take an aggregated system wide approach—it only looks at the positive results;
- It fails to count hospitals that experienced an increase in their COMs;
- It does not reflect or take into account the voluntary nature of the limits, nor does it prove that those savings are actually the result of the Dirigo Health initiative;

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- It is possible for a hospital's COM to decrease and for its charges and the prices paid for services to its patients to actually increase.

The payor representatives have proposed a method that would measure the change in Total Gross Patient Service Revenue, as outlined above, and replace this proposed measure, as well as others as described more fully herein. The charge measurement described earlier is strongly preferred by the payor caucus. However, if the DHA's proposed COM measure is adopted by the Dirigo Health Board of Directors, several improvements are required from the payors' perspective. Those required changes include:

1. Measuring all hospitals that have historically had a COM at or above 3% and whether or not they have reduced their COM;
2. Measuring hospitals that have reduced prices to payors to try to meet the 3% target during the course of the fiscal year;
3. The measure of aggregate savings must include all hospitals that meet the criteria specified in either #1 or #2, not just those hospitals that saw reductions in their COM in 2004.

- ***Case Mix Adjusted Discharge (CMAD)***

The payor representatives understand that the methodology proposed by the DHA seeks to:

- Calculate the historical three year baseline trend (arithmetic average) in case mix adjusted discharge ("CMAD) for each hospital (inclusive of outpatient costs);
- Calculate the expected CMAD for each hospital's 2004 fiscal year by using a baseline average rate of growth and then compare it to actual 2004 CMAD (on a per hospital basis);
- Multiply the differences between the expected CMAD and actual CMAD in each hospital times the number of patients served by that hospital in 2004; and
- Sum the total of individual hospital decreases in CMAD to get total savings for 2004.

The concerns with this methodology include that:

- It does not take an aggregate system wide approach—it only looks at positive results;
- When calculated for any period of time, "savings" would likely be identified because of external variables – with or without the presence of the Dirigo Health initiatives;
- It does not reflect or take the voluntary limits established with the Dirigo Health Act into account;
- It does not show that those savings are actually the result of the Dirigo Health initiative;
- The proposed methodology does not reflect changes in volume;
- The proposed methodology does not reflect changes in reimbursement by public payors such as MaineCare and Medicare;
- The proposed methodology does not reflect changes in the underlying rate of inflation;
- The proposed methodology does not recognize that it is possible for a hospital's CMAD to decrease while the charges and prices paid by its patients increase.

The payor representatives have proposed an alternative method, as described above, that would measure the change in Total Gross Patient Service Revenue and replace the CMAD measure as

well as others, as described more fully herein. The charge measurement is strongly preferred by the payor caucus, which believes that this measure is far more accurate. However, if the DHA's proposed methodology is adopted by the Dirigo Health Board of Directors, several improvements must be made to the CPAD measure as proposed. Those changes include:

1. Historical data should be adjusted for inflation;
2. The measure must reflect Cost Per Adjusted Discharge, which incorporates outpatient services into its methodology—CMAD only reflects inpatient;
3. The historical growth rate should be computed as a compounded (or "geometric") average rate of growth rather than just the arithmetic mean of the annual growth rates;
4. Each hospital's CPAD should be compared to its historical CPAD compounded growth rate;
5. The calculation must factor in the rate of inflation (the differential in the rate of change in CPAD as compared to the rate of change in hospital inflation); and
6. The measure must be an aggregate measure that includes both those hospitals for which the CPAD increased, as well as those that decreased

Voluntary Insurance Target

The payor representatives understand that the Dirigo Health Agency has proposed to:

- Measure the after tax underwriting gain as a percentage of premium for every carrier with members in Maine for the three fiscal years prior to 2004 and establish an arithmetic average for each carrier;
- Multiply the average by each carrier's 2004 premium to approximate expected underwriting gain in 2004 for each carrier;
- Measure any reductions in actual underwriting gain compared to expected underwriting gain as savings.

Again, this methodology does not:

- Reflect or take the voluntary limits into account; and
- Does not show that those savings are actually the result of the Dirigo Health initiative.

The payor representatives believe that this measurement must:

1. Be measured for one year period only since the voluntary measure was established for only one year;
2. Include only those carriers that voluntarily agreed to participate as reflected in responses to a Bureau of Insurance bulletin;
3. Include only those carriers whose average underwriting gain was at or above 3% in previous years and in their 2004 fiscal year; and
4. Count both increases and decreases for carriers described in #2 and #3.

Insuring the Uninsured (Bad Debt and Charity Care)

The payor representatives understand that the Dirigo Health Agency proposes to:

- Identify the portion of bad debt and charity care related to the uninsured and the underinsured

- Convert that total savings to a per member per month (PMPM) figure based on avoided bad debt and charity care costs for hospitals and other providers
- Determine the "incurred" member months for previously uninsured and underinsured enrollees in MaineCare or DirigoChoice;
- Multiply the enrolled member months in 2004 for previously uninsured and underinsured enrollees in MaineCare and DirigoChoice by the PMPM figure for avoided bad debt and charity care to establish the total savings.

The payor representatives agree that there are savings that result from coverage of the previously uninsured and that there may be very limited savings from changes to coverage of the previously underinsured. While the methodology suggested by the payor caucus incorporates these savings into its formula, the payor representatives have significant concerns about the proposed methodology for measuring the savings that result from a reduction in bad debt and charity care and believe that certain modifications are required to ensure the integrity of this measure. Those concerns and/or modifications include:

1. The basis for the determination of the PMPM figure of $87 per member per month was never fully explained. There is concern about the assumption about the portion of bad debt and charity care that is attributable to non-hospital providers, since that assumption was based upon information provided by two mental health hospitals, rather than physicians and other non-hospital providers;
2. The measure must take into account not only people who were covered under the MaineCare expansions that took place after July 1, 2004 but also those people who are no longer covered due to changes in eligibility after July 1, 2004;
3. Although there may be some savings associated with coverage of the previously underinsured, a number of issues exist with respect to this measurement. There has been no agreement on the definition of underinsured that was proposed by the Dirigo Health Agency and the payor representatives have expressed concerns about the appropriateness of the proposed definition, which reflects a national standard, in a state such as Maine. In addition, any recognition of savings must be offset by the fact that some of the enrollees in the DirigoChoice product have moved to *higher* deductibles and/or out-of-pocket expenses, thus *increasing* their risk of contributing to increases in bad debt and charity care;
4. The other measures outlined (previously MaineCare, previously insured, MaineCare Group A and "woodwork," and non-Dirigo previously uninsured) are inappropriate to include;
5. Bad debt and charity care must be measured on a cost basis, rather than on a charge basis to reflect actual costs that accrued to providers as a result of bad debt and charity care; and
6. Savings estimates should be adjusted to reflect the portion of these savings that are actually passed back to consumers in the form of lower prices.

The payor representatives have proposed an alternate method that would measure the change in Total Gross Patient Service Revenue and replace this proposed measure along with others as described more fully herein. This measurement is strongly preferred by the payor caucus.

Certificate of Need

Additional information that would more fully explain the proposed measurements with respect to savings resulting from Certificate of Need (CON) has been requested but has not yet been received, making it difficult to comment on the proposed measurement.

Some of the concerns of the payor representatives with respect to the proposed measurement include the following:

1. Whether or not this measure is duplicative and provides "double-counting" of savings through an overlap with other measures.
2. It is unlikely that there would be measurable savings in 2004 or 2005 as any savings would be based on third year operating costs avoided and the projects delayed would not have been operational in 2004 or 2005, even if they had not been delayed by the moratorium.
3. While it is possible that the one-year moratorium will result in some savings, those savings are not includable at the present time, but may be included at an appropriate time in the future; and
4. Any savings resulting from the CON initiatives should be apportioned to reflect the savings attributable to private-pay patients only.

It should be noted that these are only preliminary comments; as previously noted, additional information on this proposed measure is needed in order for the payor representatives to make informed comment.

Budget Initiatives

The payor representatives understand that the Dirigo Health Agency has proposed that the measurement of the savings resulting from the Dirigo Health initiatives should include the following:

- Approximately $18 million in increased MaineCare reimbursement to physicians;
- Approximately $139 million in increased prospective interim payments to hospitals, including settlement of prior PIP payment periods; and
- Approximately $90 million paid to 12 hospitals in settlement of litigation.

The payor representatives believe that none of these payments are directly attributable to the Dirigo Health reform initiatives and that they are unlikely to result in any cost reductions to private-pay health care consumers and payors. The specific concerns include the following:

1. Any increases in physician reimbursement are unlikely to result in savings to payors and certainly not on a dollar for dollar basis; again, the increase in reimbursement is not, in any case, a "Dirigo" initiative;
2. Hospital settlement payments do not increase the amount of hospital reimbursement, only the timing of the payments—this will not result in any savings to payors and, again, it is not a Dirigo initiative. The fact that the issue was referenced in the Commission to Study Maine's Hospitals' Report to the legislature does not make it a Dirigo Health reform initiative.

Review of Board's Decision

RE:	DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE SECOND ASSESSMENT YEAR (2007)	))))	DECISION

At the request of Counsel, Mercer reviewed the Board's decision regarding the determination of AMCS for the Year 2 SOP. The most relevant sections of the Board's decision (dated June 6, 2006) addressing the savings methodology and resulting calculations are covered by:

- III.C.1: Hospital Savings Initiatives (CMAD)
- III.C.2: Uninsured Savings Initiatives (including subsections a,b, and c)
- III.C.3: Certificate of Need and Capital Investment Fund Initiatives (CON/CIF)
- III.C.4: Health Care Provider Fee Initiatives

III.C.1: Hospital Savings Initiatives (CMAD)

Summary

The Board adopted Mercer's methodology but used a growth rate calculated by taking the median growth rate of 4.7% from Chamber Exhibit #21, Table 7. This results in savings of $14.5 million from CMAD.

Issues/Concerns

Mercer has significant concerns with the Board's use of the median growth rate as opposed to the geometric mean (also commonly referred to as compound annual growth rate) to determine the projected CMAD in Year 2 in the absence of Dirigo to determine whether or not savings occurred. It is not advantageous to the State and not appropriate in our professional opinion.

The mean and the median are the most commonly used measures of a group of measures called measures of central tendency. Measures of central tendency are used to quantify the relationships of a group of numbers into a single number, or said another way, they can be helpful in describing how a group of numbers tend to be related. For purposes of this analysis, Mercer only considered three measures:

- Arithmetic Mean or Simple Average,
- Geometric Mean or Compound Annual Average Growth Rate, or
- Median

Mercer's goal was to use one of these measures to project the actual 2003 CMAD figure forward to 2005. Thus, we wanted to use the measure that has the best predictive value to provide as accurate a future projection as possible. Table 1 below shows the actual values from our CMAD calculations for our baseline period of SFY2000 to SFY2003.

Table 1. CMAD and Annual Percentage Change

Year	CMAD	Percentage Change	Arithmetic Mean	Geometric Mean	Median
2000	$4,868				
2001	$5,097	4.72%			
2002	$5,613	10.12%			
2003	$5,800	3.32%			
			6.05%	6.01%	4.72%

Table 2 addresses how the various measures are calculated and their predictive properties. In general, the mean and median each have advantages and disadvantages when used to describe data sets. Overall, however, the mean depends on all of the actual values in a data set, but the median is dependent on only one of the actual values and its relative position among the values, not the actual values themselves, and this is extremely important when using either of these measures for their predictive properties.

Table 2. Mean vs. Median: Projecting CMAD Forward

	Arithmetic Mean	Geometric Mean	Median
Calculation	Add the 3 annual percentage increases and divide by 3. (4.72+10.12+3.32)/3	Take the cube root of the 3 annual growth factors. Subtract 1 to convert to a percentage increase. $(1.0472 \times 1.1012 \times 1.0332)^{1/3} - 100\%$	Determine which of the 3 percentage increases is where half the values are above and half are below. 10.12 High 4.72 Midpoint 3.32 Low
Result	6.05%	6.01%	4.72%
Role	Tells what the average rate of increase was from 2000 to 2003	Tells the actual compound annual rate of increase from 2000 to 2003	Tells the relative distribution of each of the three years' percentage increase
CMAD Predictive Value for 2003	$\$4,868 \times (1.0605)^3 = \$5,806$	$\$4,868 \times (1.0601)^3 = \$5,800$	$\$4,868 \times (1.0472)^3 = \$5,590$
CMAD Actual	$5,800	$5,800	$5,800

	Arithmetic Mean	Geometric Mean	Median
2003 Value			
Difference	($6)	$0	$210
Conclusion	The arithmetic mean, based on the actual values, is an excellent predictor of the CMAD actual value for 2003, with an error of only $6.	The geometric mean, based on the actual values, exactly predicts the CMAD actual value for 2003, with no error ($0).	The median, which looks only at the relative distribution of the values, is an extremely poor predictor of the CMAD actual value for 2003, with an error of $210.
Bottom Line	The error using the median is on the order of magnitude of the annual variations in CMAD and so clearly illustrates the inappropriateness of using the median.		

Table 3 shows an example of the shortcomings of the median due to its focus only on the relative position of the values, not on all of the actual values themselves. This example, where the end result for the 2003 CMAD is identical, shows how important it is to use the mean when using either of these measures for their predictive properties.

Table 3. *EXAMPLE* CMAD and Annual Percentage Change

Year	*EXAMPLE* CMAD*	*EXAMPLE* Percentage Change	Arithmetic Mean	Geometric Mean	Median
2000	$4,868				
2001	*$5,160*	*6.00%*			
2002	*$5,573*	*8.00%*			
2003	*$5,800*	*4.08%*			
			6.03%	*6.01%*	*6.00%*

* Example CMAD calculations done using the example percentage change figures in the adjacent column.

Table 4 shows how dramatically the median will shift although the resulting 2003 CMAD is identical to that within the actual SOP Year 2 calculations.

Table 4. EXAMPLE Mean vs. Median: Projecting CMAD Forward

	Arithmetic Mean	Geometric Mean	Median
Calculation	Add the 3 annual percentage increases and divide by 3. (6.00+8.00+4.08)/3	Take the cube root of the three annual growth factors. Subtract 1 to convert to a percentage increase. $(1.06x1.08x1.0408)^{1/3} - 100\%$	Determine which of the 3 percentage increases is where half the values are above and half are below. 8.00 High 6.00 Midpoint 4.08 Low
Result	6.03%	6.01%	6.00%
Bottom Line	The ending CMAD is identical to the actual 2003 CMAD in this example ($5,800), yet the median has increased dramatically from 4.72% in the actual to 6.00% in this case. On the other hand, both of the mean calculations have remained essentially unchanged. This example clearly shows the advantage of using the mean – while the median *may* be a good predictor of the actual values *(depending upon the relative distribution of the values)*, the mean, and especially the geometric mean, by definition will exactly predict the actual value.		

Finally, Dirigo needs to certain to retain the right to update the data. In Year 1 of the SOP, only approximately 3-5% of the data was estimated. If the calculation for SOP in future years is carried out using a timeline similar to this Year 2 process, a significant portion of the data will have to be estimated annually. In Year 2, approximately 20-25% was estimated, although this figure is skewed due to Maine Medical Center's MCR failure to file its latest MCR in a timely manner. To remove any potential bias for or against the savings estimate, the State needs the ability to update the data as the MCRs become available.

III.C.2: Uninsured Savings Initiatives (including subsections a,b, and c)

Summary

The Board adopted Mercer's methodology.

Issues/Concerns

As with CMAD, Dirigo needs to make certain it continually reserves the right to update the data. It is particularly important because using the most recent data used will be the most advantageous to the State. In addition, we have set the precedent of 0% growth rate in all of our calculations based on having insufficient historical data for projecting the

future growth rates. For future calculations, Dirigo should begin using an increasing trend rate to more closely mirror the actual trend in increasing enrollment. The net impact would be to raise the savings estimate slightly and at this point, the State has sufficient data to establish a credible, robust trend line.

III.C.3: Certificate of Need and Capital Investment Fund Initiatives (CON/CIF)

Summary

The Board adopted Mercer's methodology.

Issues/Concerns

This is a new methodology based on the feedback from the Superintendent during the Year 1 process. Again, if the State is required to follow a timeline similar to that used during Year 2, the State needs the right to update savings for the most recent data available, which should become available in late June per the State. An additional savings estimate incorporated for Year 2 was the deferral process – hospitals voluntarily agreeing to defer their project's consideration into future years so as to increase the likelihood of approval using a future year's CIF limits. The State needs to make certain it has a tracking mechanism to identify and treat these deferrals consistently. Also, the State committed to looking at potential offsetting due to overlap in future years savings estimates. We need to be certain to build in a mechanism for the estimate overlap in future years.

III.C.4: Health Care Provider Fee Initiatives

Summary

The Board adopted Mercer's methodology.

Issues/Concerns

This is the identical methodology approved by the Superintendent during the Year 1 process that attributed savings to the appropriate fiscal year.

Consumers for
AFFORDABLE
Health Care
COALITION

Advocating the right to health care for every man, woman and child.

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June 20, 2006

Exhibit 4 to CAHC Intervenor Brief

Hand-delivered

Ms. Karynlee Harrington, Executive Director
Dirigo Health Agency
211 Water Street
Augusta, Maine 04330

Re: Request for Documents Pursuant to Maine Freedom of Access Law

Dear Ms. Harrington:

This is a formal request for public records pursuant to the Maine Freedom of Access Act, 1 M.R.S.A. §§ 401 et seq. ("FAA"). Your written response to this request is required by law within five (5) working days, pursuant to 1 M.R.S.A. § 409.

We request that the Dirigo Health Agency ("DHA") make available for inspection and copying, pursuant to 1 M.R.S.A. § 408, all "Public Records," as defined below, in the possession or control of the DHA, which relate or pertain to, involve in any way, or which have been produced by or come into the possession of DHA concerning the following:

> Any expert analyses and/or reports, produced subsequent to the hearing before the Board and which is relevant to the Board's Decision dated June 6, 2006 regarding the calculation of CMAD, specifically the use of a 3-year median rate of growth as compared to a 3-year average rate of growth as set forth in Chamber Exhibit #21.

We will pay any reasonable copying expense. To the extent that DHA at one time had possession or control of Public Records that are covered by this request, but no longer has possession or control of those materials, please identify any such Public Records.

If the DHA objects to the provision of any of these Public Records on the basis that they are not subject to the Freedom of Access Act or otherwise not subject to disclosure, please specify in writing the nature of the materials which DHA refuses to provide and the legal basis for that denial within five (5) days, pursuant to 1 M.R.S.A. § 409.

For purposes of this request, the following terms have the indicated meanings:

1. "Public Record" means public record as defined by 1 M.R.S.A. § 402(3), (3-A), as well as all documents, letters, memoranda, notes, minutes, e-mail (electronic mail), studies (including all data, measurements, estimates, calculations, and/or analysis received, used or produced in conjunction with any study), testing results, data, analysis, measurements, estimates, calculations, workpapers, reports, drafts, telephone logs, message slips or any recordation of messages, photographs, sketches, drawings, and maps produced, received, in the possession or control of DHA whether actually on paper or some other hard copy or contained on some form of computer, magnetic, or optical media (including information on computer hard-drives and backup tapes or CDs) or the like.

2. Dirigo Health Agency means the agency, its staff and its board, councils, commissions, divisions, and bureaus, and all commissioners, employees, consultants and contractors thereof.

Thank you for your cooperation. Please contact me at your first convenience to arrange a reasonable time and place for inspection and copying.

Very truly yours,

Joseph P. Ditré, Esq.
Executive Director serving as Legal Counsel

pc: Kelly Turner, Assistant Attorney General
William Laubenstein, Assistant Attorney General

h:/consumerhealthlawprogram/DirigoLegalProceeding2006/CAHCInfoRequest/060620CAHCFOAADHA

STATE OF MAINE
DIRIGO HEALTH AGENCY
211 WATER STREET, 53 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0053

JOHN ELIAS BALDACCI
GOVERNOR

KARYNLEE HARRINGTON
EXECUTIVE DIRECTOR

June 21, 2006

Mr. Joseph P. Ditre, Esq.
Executive Director
Consumers for Affordable Health Care Coalition
39 Green Street
Augusta, Maine 04338-2490

Re: Request for Documents Pursuant to Maine Freedom of Access Law

Dear Mr. Ditre:

This letter responds to your Freedom of Access request addressed to me in my capacity as Executive Director of the Dirigo Health Agency, which was received on June 21, 2006.

Attached please find a copy of a report that was prepared by Mercer, Government Human Services Consulting summarizing the decision made by the Dirigo Board of Directors regarding the Aggregate Measurable Cost Savings for the Second Assessment Year.

Please contact me at (207) 287-9964 with further questions.

Sincerely,

Karynlee Harrington

Karynlee Harrington